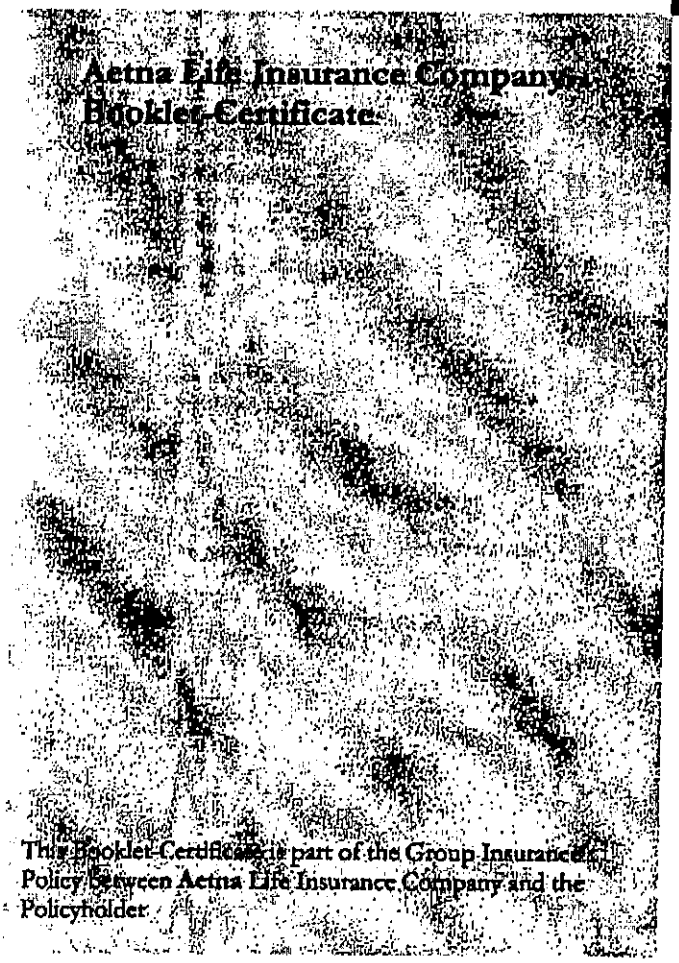
EXHIBIT C

BENEFIT PLAN

Prepared Exclusively for Laborers Local No. 754 Joint Benefit Funds

Open Access Managed Choice -Active Union Participants

What Your Plan Covers and How Benefits are Paid



We want you to know™

Aetna®

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	Laborers Local No. 754 Joint Benefit Funds
Group Policy Number:	GP-475051
Effective Date:	March 1, 2009
Issue Date:	June 1, 2010
Booklet-Certificate Number:	5

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N 02-005 02)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident, injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor Union participants of **Aetna** or its affiliates.

When Your Coverage Begins

(GR-9N 29-005-01-NY)

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the Union participant.

Who Can Be Covered

Union Participants

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Eligible Classes

You are in an eligible class if:

- You are a regular full-time Union Participant, as defined by the Fund, and
- You are employed at the Fund's New York, Florida, New Jersey, Pennsylvania, West Virginia, Kentucky, Louisiana, Minnesota, Georgia or Texas location; employed by a participating employer who has a collective bargaining agreement with Laborers Local 754 requiring the participating employer to contribute to the Welfare Fund on behalf of Union Participants covered under the agreement; and eligible to participate in the Plan according to the rules of the eligibility established by the Board of Trustees.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

Your Eligibility Date is the effective date of this Plan if you were in an Eligible Class at the time, and if the Trustees certify that you would have been eligible for coverage on that date under the terms of the prior plan. Otherwise, your Eligibility Date is the date you enter the Eligible Class.

After the Effective Date of the Plan

Initial and Subsequent Eligibility - Initial and Subsequent Eligibility is based on your hours accrued via the "Remittance System" during the Eligibility Periods. A minimum of 500 accrued hours is necessary for six months of coverage. Insurance Periods are as follows:

Covered Employment in the Eligibility Period	Provides Coverage for the following corresponding Benefit Period
December - May	August 1st - January 31st
June - November	February 1st - July 31st

The Rules for Eligibility are subject to change by the vote of the Trustees, including any temporary waiver or modification which the Trustees may determine to be in the best interest of the Welfare determine to be in the best interest of the Welfare Fund and Fund and eligible Fund participants and their Dependents.

"Covered Employment" shall mean employment in the jurisdiction of Laborers Local No. 754 by an Employer who is obligated to make contributions to this Welfare Fund.

Covered Employment shall also be deemed to include full time Employees of Laborers Local No. 754.

All questions with respect to eligibility shall be determined by the Trustees, whose decision shall be final.

Military Reinstatement
If your coverage terminates because you enter the military service on an active basis, and if you are re-employed by a Participant Employer within the 60 day period after your discharge date, your Eligibility Date for coverage under this policy will be determined by the Fund, consistent with applicable law.

Bank Arrangement
Bank: For this purpose, hours of Covered Employment will mean the total hours in your "Bank" on the last day of the month. Hours sufficient to maintain your eligibility will, if available, be deducted from your "Bank".

Bank Hours Carryover Provision- If an eligible active participant reports more than 600 Hours in any Eligibility Period, the reported hours in excess of 600 may be carried over and "Banked" for use in succeeding insurance periods.

At any time your "Bank" shall consist of the total hours of Covered Employment worked. At any time coverage is not in force any hours in your Bank will be subject to cancellation, in accordance with the Trustee's rules. At no time will your Bank exceed 800 hours. Only reported contributory hours can be banked. No Disability or Worker's Compensation hours will be used.

Banked Hours may be used only if the Union Participant is registered with Laborers Local 754 as being ready, willing, able and available for work in contributory employment at the start of the Insurance Period in which such Banked Hours are to be utilized.

Obtaining Coverage for Dependents *(GR-9N 29-010 02)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; and
- Your dependent children.

Aetna will rely upon the Fund to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children *(GR-9N 29-010 02)*

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 24, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support* until December 31st.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under the plan as:

- Both an Union Participant and a dependent; or
- A dependent of more than one Union Participant.

How and When to Enroll *(GR-9N 29-015 03 NY)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to the Fund within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment *(GR-9N 29-015-HRPA NY)*

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage,** but such written statement is required only if the Fund requires the statement and gives you notice of the requirement, and the notice explains the consequence of failing to provide such statement; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - the employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - cessation of a dependent's status as an eligible dependent as such is defined under this Plan; or
  - you or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You will need to enroll yourself or a dependent for coverage within 31 days of when other **creditable coverage** ends. Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period. However, coverage for a newborn child will be provided from the date you give notice to **Aetna**.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's health insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, **Aetna** will nevertheless provide the coverage for the child and for you, if necessary, regardless of whether you request coverage within the 31 days or not.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins

Your Effective Date of Coverage

Initial benefit coverage for an Active Fund participant will start at his effective date as determined by the Rules of Eligibility, except that if the Active Fund participant is absent from active work on account of injury or sickness at his initial effective date or on the date he would be entitled to additional or increased benefits, such benefit coverage will begin when he returns to, or becomes available for return to, contributed employment.

Your Dependent's Effective Date of Coverage

Fund participants are required to submit Proof of Dependents before such Dependent is considered eligible for benefits. An Active Fund participant, who fails to submit the required Proof of Dependents, will be initially enrolled as a Single Individual. Coverage for Dependents will begin on the first day of the month following receipt of required proof of dependents by the Fund office.

The proof of dependent rule also applies to children born while you are on active coverage. You must inform the Fund Office when a child is born and submit copy of child's Birth Certificate, listing the covered Participant as parent of such child. If you notify the Fund Office and provide copy of birth certificate within the 30 days after child's birth, -OR- within 30 days of issue date of birth certificate, such child's coverage will be effective on his/her date of birth. Notification and submission of required proof after 30 days will result in child's coverage being effective the first day of the month after receipt of documents.

Below is a list of required documents, which must be submitted to the Fund Office for Dependents' coverage:

(A) Participants with Dependent Spouses -A copy of Certificate of Marriage must be submitted to the Fund Office.

(B) Participants with Dependent Children -A copy of Birth Certificate for each dependent child must be submitted to the Fund Office. The Birth Certificate must list the covered Participant as parent of such child. In the event that you are not in possession of a Birth Certificate copy of a Court Order naming you as Guardian, must be submitted.

(C) Participants with Dependent Step-Children -A copy of Court Order appointing Participant as Legal Guardian of such Step-Child is required.

If you are not in possession of Court Order, a signed, Notarized Affidavit --completed by the Participant and stating that such Participant is legally responsible for all medical expenses incurred by such Step-Child, and there are no other benefits due from Child's Natural Parent --must be submitted, together with copy of Birth Certificate for such Step-Child. Birth Certificate must list parent's name.

If a Dependent is hospital confined on account of injury or sickness at his initial effective date or on the date he would be entitled to additional or increased benefits, such benefit coverage for that condition will begin after final discharge from the hospital.

If a newborn child incurs charges because of injury, sickness, congenital defects or abnormalities or premature birth, benefit coverage begins from birth -provided participant notifies the Fund Office and submits required documentation as outlined above.

Benefit coverage for both Fund participant and Dependents will exclude payment of expenses incurred before the person's effective date of eligibility.

How Your Medical Plan Works

(GR-9N 08-005 01 NY)

Common Terms

Accessing Providers

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are **medically necessary.**
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet-Certificate in a safe place for future reference.

Common Terms *(GR-9N 08-010-01) (GR-9N 08-005 01 NY)*

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Gatekeeper PPO Medical Plan *(GR-9N 08-020 01 NY)*

This Preferred Provider Organization Gatekeeper PPO medical plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury.** It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Gatekeeper PPO plan, you can directly access any **physician, hospital** or **other health care** provider (**network** or **out-of-network**) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers.**

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers, Exclusions, Limitations* and *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This Gatekeeper PPO plan provides access to covered benefits through a network of health care providers and facilities. These **network providers** have contracted with **Aetna,** an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge.** This Gatekeeper PPO plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses.**

Your **deductibles**, **copayments**, and payment percentage will generally be lower when you use participating **network providers** and facilities.

Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefit* sections and your *Schedule of Benefits* to determine if any services are limited to network coverage only.

Your out-of-pocket costs may vary between **network** and **out-of-network** benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet-Certificate. If **Aetna** determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Reporting of Claims* section of this Booklet-Certificate and the Complaints and Appeals Health Amendment included with this Booklet-Certificate.

To better understand the choices that you have with your Gatekeeper PPO plan, please carefully review the following information.

How Your Gatekeeper PPO Medical Plan Works *(GR-9N 08-030-01)*

The Primary Care Physician: *(GR-9N 08-030-01)*

To access network benefits, you are encouraged to select a **Primary Care Physician (PCP)** from **Aetna**'s network of providers at the time of enrollment. Each covered family member may select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of participating providers in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory through your policyholder or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, or pediatrician. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on **Aetna**'s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna**'s receipt and approval of the request.

Specialists and Other Network Providers

You may directly access **specialists** and **other health care** professionals in the network for covered services and supplies under this Booklet-Certificate. Refer to the **Aetna provider directory** to locate network **specialists, providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

(GR-9N 08-035-01)

Important Note

ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care providers. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Cost Sharing For Network Benefits *(GR-9N 08-045 01 NY)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- For certain types of services and supplies, you will be responsible for any **copayments** shown in the *Schedule of Benefits*.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply. You will be responsible for your **coinsurance** up to the **coinsurance limit** applicable to your plan.
- Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **coinsurance limit**. Refer to the *Schedule of Benefits* section for information on what expenses do not apply. Refer to your *Schedule of Benefits* for the specific **coinsurance limit**, amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **deductible, copayment**, or **coinsurance** amounts, or any non-covered expenses that you incur.

Cost Sharing for Out-of-Network Benefits *(GR-9N 08-045 01 NY)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **coinsurance limit** applicable to your plan.
- Your **coinsurance** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.
- Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **coinsurance limit**. Refer to the *Getting Started: Common Terms* section for information on what expenses do not apply. Refer to your *Schedule of Benefits* for specific dollar amounts.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.

Services and Supplies Which Require Precertification *(GR-9N 08-065-01)*

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**
- **Stays** in a **skilled nursing facility**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **hospice** facility
- Outpatient **hospice care**
- **Stays** in a **residential treatment facility** for treatment of mental disorders, alcoholism or drug abuse treatment
- **Home health care**
- Private duty nursing care

Emergency and Urgent Care *(GR-9N-27-005-01)*

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent condition.**

In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **primary care physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **PCP** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition (one that does not meet the criteria above), your benefits will be reduced. Please refer to the *Schedule of Benefits* for specific details about the plan.

Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

Important Reminder

With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

In Case of an Urgent Condition *(GR-9N-27-010-01)*

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **PCP**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna**'s online provider directory at www.aetna.com.

Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-urgent condition (one that does not meet the criteria above), the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder

If you visit an **urgent care provider** for a non-urgent condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **PCP**.

You may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductible and coinsurance** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Important Notice

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Requirements For Coverage *(GR-9N 5-09-005-01 NY)*

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Clinical Review Criteria Requests

If you or your covered dependent needs additional information on a specific clinical issue, you may request a clinical review criteria by submitting written request to Aetna. The written request must contain the following information:

- Person's name; address; and telephone number.
- A request for the clinical review criteria; which Aetna would utilize in making a coverage determination involving a specific condition, treatment or device.

The written request should be sent to the following address:

Aetna
CRC Requests - Mail Code: F074
3 Independence Way
Princeton, NJ 08540

Aetna will take into consideration the person's individual situation in applying the clinical review criteria.

For questions, or further assistance, the person should call the Customer Services toll-free telephone number shown in the Identification Card.

Important Note
Not every service, supply or prescription drug fitting the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to your *What the Plan Covers* and *Schedule of Benefits* for the plan limits and maximums.

In case of a denial of coverage, you have full advantage of all appeal rights available under New York State insurance law.

What The Plan Covers

(GR-9N 11-005 01 NY)

Gatekeeper PPO Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Wellness

Routine Physical Exams

Covered expenses include charges made by your **primary care physician** for routine physical exams for person's age 19 or more. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children from birth through age 18 also include:

- An initial **hospital** check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

Preventive Health Care Services Expenses *(GR 9 NS 11-005 01 NY)*

This plan will pay for charges for preventive health care services provided in connection with a routine physical exam of a dependent child under 19 years of age, as follows. These charges are not subject to deductible or any lifetime maximum benefit. These services may be provided in a **hospital** or **physician's** office.

An initial hospital checkup and well-child visits scheduled in accordance with the prevailing standards of a national association of pediatric physicians designated by the New York State commissioner of health.

At each visit, services in accordance with the prevailing clinical standards of the designated association, including:

- A medical history;
- a complete physical examination;
- developmental assessment;
- anticipatory guidance;
- appropriate immunizations;
- laboratory tests.

All necessary immunizations recommended by the Advisory Committee on Immunizations Practices of the U.S. Public Health Service and the Department of Health of The State of New York, and in accordance with the minimum benefits mandated by the State of New York.

Not covered are charges for:

- Services which are covered to any extent under any other part of the plan;
- Services for diagnosis or treatment of a suspected or identified illness or disease;
- Medicines or drugs;
- Appliances, equipment or supplies;
- Premarital exams; dental exams; hearing exams; or exams related in any way to employment.

Routine Cancer Screenings

The plan will pay for charges incurred for routine cancer screening, as follows:

Mammograms:

- Upon recommendation of a **physician**, a mammogram at any age for females having a history of breast cancer or who have a first degree relative with a prior history of breast cancer;
- A single baseline mammogram for covered females aged 35 through 39; and
- An annual mammogram for covered females aged 40 or older.

One gynecological exam, including Pap smear, every twelve months.

The following coverage for diagnostic screening of prostatic cancer:

- Standard diagnostic tests, including but not limited to a digital rectal exam and one prostate specific antigen (PSA) test at any age for males having a prior history of prostate cancer; and
- An annual standard diagnostic examination, including but not limited to a digital rectal examination and a prostate specific antigen test for males age 50 or more who are asymptomatic and for males age 40 or more with a family history of prostate cancer or other prostate cancer risk factors.

Fecal occult blood test, sigmoidoscopy, colonoscopy, and double contrast barium enema.

Any age limits shown above do not apply to any person who is at high risk for the cancer being screened.

Early Intervention Services Expenses

The plan will pay the following charges even though they may not be incurred in connection with an **injury** or **disease**. Benefits are payable on the same basis as any other sickness. They are included only for a dependent child:

- Until September 1 of the calendar year in which the child attains the age of 3 years; if the child is born between January 1 and August 31 of that calendar year.
- Until January 2 of the calendar year following the calendar year the child attains the age of 3 years; if the child is born between September 1 and December 31 of the preceding calendar year.

The dependent child must be certified by the New York Department of Health as eligible to participate in the Early Intervention Program. You must submit proof of such qualification with the initial claim.

Early Intervention Services Expenses
These are the charges incurred for Early Intervention Services.

Early Intervention Services: These are services, designed to offer a comprehensive array of educational, developmental, health and social services to eligible infants, children and their families as specified in program regulations. They include, but are not limited to, the following:

- Speech and language therapy given in connection with a speech impairment resulting from a congenital abnormality, disease or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease or injury.
- Clinical psychological tests or treatment.
- Skilled nursing services, on a part-time or intermittent basis, given by an R.N. or by an L.P.N.

Benefits paid for early intervention services will not be applied against any maximum lifetime or annual limits specified in this Booklet-Certificate. However, visit limitations and other terms and conditions of the Booklet-Certificate will continue to apply to early intervention services. Visits used for Early Intervention Services will not reduce the number of visits otherwise available under the coverage for such services.

Family Planning Services

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an **illness** or **injury**. Refer to the *Schedule of Benefits* for any frequency limits that apply to these services, if not specified below.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by the Fund; and
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Also see section on pregnancy and infertility related expenses on a later page.

Bone Mineral Density Measurement or Test, Drug and Devices *(GR-9N 11-085-NY)*

Covered expenses include charges incurred for bone mineral density measurements or tests, including drugs and devices, for individuals(a) meeting the criteria under the federal Medicare program or the National Institutes of Health; or (b) previously diagnosed as having osteoporosis or a family history of osteoporosis; or (c) with symptoms or conditions indicative of the presence or of significant risk of osteoporosis; or (d) on a prescribed drug regimen posing a significant risk of osteoporosis; or (e) with lifestyle factors to such a degree posing a significant risk of osteoporosis; or (f) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Bone mineral density measurements or tests, drugs and devices include those covered under the federal Medicare program as well as those in accordance with the criteria of the National Institutes of Health, including dual energy X-ray absoptiometry.

Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

Limitations

Coverage is subject to any applicable Calendar Year **deductibles, copays** and **coinsurance** percentages shown in your *Schedule of Benefits.*

Vision Care Supplies

You and each of your covered dependents are eligible for **covered expenses** for prescription lenses and frames, or prescription contact lenses up to the vision supply maximum listed on your *Schedule of Benefits.*

Important Reminder

Refer to the *Schedule of Benefits* for information about any applicable maximums that apply to vision care supplies.

Hearing Exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **coinsurance** shown in your *Schedule of Benefits.*

Primary and Preventive Obstetric and Gynecological Care *(GR-9N-11-018-01 NY)*

Covered expenses include charges made by any provider of obstetric and gynecological services of the **Covered Person's** choice for primary and preventive obstetric and gynecological care, or any other care, related to a pregnancy or to an acute gynecological condition.

The plan covers charges for 2 examinations for primary and preventive obstetric and gynecological care in any Calendar Year.

Physician Services *(GR 9N S 11-20 01 NY)*

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by a qualified **physician** for a second surgical opinion on the need for surgery; and a second medical opinion by an appropriate specialist (including, but not limited to a specialist affiliated with a specialty care center for the treatment of cancer) in the event of a positive or negative diagnosis of cancer; or a recurrence or cancer; or a recommendation of a course of treatment for cancer. The opinion may be rendered by either a **network** or a **non-network** specialist.

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:
Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

E-Visits

Covered expenses include charges made by your **primary care physician (PCP)** for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.

Hospital Expenses *(GR 9N S 11-030 01 NY)*

Covered medical expenses include services and supplies provided by a **hospital** during your **stay.**

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay.** Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay.**

Covered expenses include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating, cytoscopic and recovery rooms.
- Intensive or special care facilities and equipment.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy, chemotherapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, electrocardiographs, electroencephalographs, laboratory testing and diagnostic services.
- Medications, sera, biological and vaccines.
- Intravenous (IV) preparations, visualizing dyes.
- Discharge planning.
- Dressings and casts.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for:

- Covered services and supplies provided by the outpatient department of a hospital;
- Hospital services rendered within 24 hours after an accidental injury; and
- X-ray and lab test in the outpatient department of the hospital, to the extent such services would be provided if an inpatient.

Important Reminders

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

(**NOTE:** The duration and any **stay** for patients undergoing a lymph node dissection or lumpectomy for treatment of breast cancer, or a mastectomy, will be as determined by the attending **physician**, in consultation with the patient.)

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your **stay**.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **coinsurance** and maximum benefit limits.

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment for an **emergency medical condition**.

Important Reminder

With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an urgent condition.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment of an urgent condition.

If you visit an **urgent care provider** for a non-urgent condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits.*

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician**'s or **dentist**'s office.

Important Note
Benefits for surgery services performed in a **physician**'s or **dentist**'s office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital, surgery center** on the day of the procedure;
- The operating **physician**'s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

Birthing Center

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Ambulatory Care

Covered expenses include charges incurred for ambulatory care in a **hospital's** outpatient department of in a **physician's** office. Ambulatory care includes: services for diagnostic X-rays; laboratory and pathological examinations; physical and radiation therapy; services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy.

The services and supplies must be:

- Related to and necessary for treatment or diagnosis of your **illness** or **injury**;
- Ordered by a **physician**;
- In the case of physical therapy, furnished for the same illness or injury for which you were hospitalized or for surgery (care must start no later than 6 months after discharge from the **hospital** or surgery and is limited to 365 days following surgery or discharge from the **hospital**).

Home Health Care *(GR 9 NS 11-050 01 NY)*

Covered expenses include charges for home health care services when ordered by a **physician** provided:

- The charges are made by a **home health care agency**; and
- The care is given under a **home health care plan**; and
- The care is given to you in your home while you are homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by a **R.N.** or by a **L.P.N.**
- Part-time intermittent home health aide services provided in conjunction with and in direct support of patient care.
- Physical, occupational and speech therapy.
- Medical supplies, prescription drugs and medications and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you been confined in a **hospital** or **skilled nursing facility** (as defined in Title XVIII of the Social Security Act).

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit. Each 4 hours of home health aide services is one visit.

Limitations
Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Transportation.
- Services that are for **custodial care**.

Important Reminders
The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Skilled Nursing Facility
Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Limitations
Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.

Hospice Care *(GR 9N S 11-070 01 NY)*
Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies.
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs;**
  - Psychological counseling; and
  - Dietary counseling.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate.**
- More than 5 visits for bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

Important Reminders

Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Other Covered Health Care Expenses *(GR-9N S-11-080 01 NY)*

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service *(GR 9 NS 11-080 01 NY)*

Covered expenses include the following:

Emergency Transportation

Covered expenses include charges made by an ambulance service, issued a certificate to operate under the New York Public Health Law, for **prehospital emergency medical services.** Payment under the Plan will be payment in full for the services provided. An ambulance service that is so reimbursed by the Plan will not seek any reimbursement from, or have any recourse against you, except for the collection of **copays, coinsurance** or **deductibles** for which you are responsible under the Plan.

"Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-airborne transportation of a covered person from the place where he or she is injured or stricken by illness to the **hospital** where treatment is given. If the person utilizes non-airborne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (1) placing the health of the covered person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others' in serious jeopardy; (2) serious impairment to such covered person's bodily functions; (3) serious dysfunction of any bodily organ or part of such covered person; or (4) serious disfigurement of such covered person.

Non-Emergency Transportation

Covered expenses include charges by a professional ambulance service for the necessary non-emergency transfer of a covered person via ground ambulance or a medical van.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

Diagnostic and Preoperative Testing *(GR-9N S-11-085 01 NY)*

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services, lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician, hospital** or licensed radiological facility or lab.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductible, coinsurance** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital, surgery center, physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and:

- The test are related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Reservations for a bed or for an operating room were made prior to the tests:
  - The test are completed within 7 days before your surgery;
  - The test are performed on an outpatient basis;
  - The test would be covered if you were an inpatient in a **hospital**;
  - The test are not repeated in or by the **hospital** or **surgery center** where the surgery will be performed;
  - Test results appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Important Reminder

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the test, however surgery will ***not*** be covered.

Durable Medical and Surgical Equipment (DME) *(GR 9 NS 11-090 01 NY)*

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **DME** includes equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment **does not** include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is **Aetna's**.

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible, coinsurance** and benefit maximums.

Experimental or Investigational Treatment

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

Pregnancy Related Expenses *(GR 9 N S 11-100 01 NY)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

If the mother is discharged earlier, the plan will pay for two post-delivery home visits by a health care provider. This will not be subject to any deductible or copay and will not count toward the maximum number of visits under the home health care benefit.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Prosthetic Devices *(GR 9N S 11-110 01 NY)*

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of illness or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support.

Short-Term Rehabilitation Therapy Services *(GR 9N-11-120 01 NY)*

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on the *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient **Hospital and Skilled Nursing Facility** benefits provision in this Booklet-Certificate:

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered;
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by the Fund;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a **stay** in a **hospital, skilled nursing facility,** or **hospice facility except as stated above;**
- Services not performed by a **physician** or under the direct supervision of a **physician;**
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies *(GR-9N 11-125 01 NY)*

Covered expenses include charges made by a **physician, hospital,** or **surgery center** for reconstructive services and supplies, including:

- Surgery to correct the result of an accidental **injury** provided the surgery occurs no more than 24 months after the **injury**. For a covered child, surgery will be covered up to age 18 or up to 24 months after the **injury,** whichever period is longer. **Injuries** that occur during surgical procedures or medical treatments are not considered accidental injuries, even if unplanned or unexpected.
- Surgical implantation or attachment of covered prosthetic devices.
- Surgery to correct a gross anatomical defect present at birth. The surgery will be covered if the defect results in severe facial disfigurement or significant functional impairment of a body part; and the purpose of the surgery is to improve function.

Reconstructive surgery which is incidental to or follows surgery for trauma, infection or other diseases of the involved part, or necessary due to a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Reconstructive Breast Surgery

Covered expenses include (i) reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. (ii) surgery on the other breast to make it symmetrical with the reconstructed breast; and (iii) physical therapy to treat complications of mastectomy, including lymph edema, in as manner determined by you and your attending **physician.**

Specialized Care *(GR-9N S-11-135 01 NY) (GR-9N 11-190-01)*

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details on any applicable **deductible**, **coinsurance** and maximum benefit limits.

Services Provided by a Center for Eating Disorders

Covered expenses include charges made by a comprehensive care center for eating disorders to provide a coordinated, individualized plan of care for individuals with eating disorders, including all necessary non-institutional, institutional and practitioner services and treatments, from initial patient screening and evaluation to treatment , follow-up care and support.

Eating disorder includes, but is not limited to: conditions such as anorexia nervosa, bulimia and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, or other medical and mental health diagnostic references generally accepted for standard use by the medical and mental health fields.

Diabetic Equipment, Supplies and Education *(GR-9N 11-35 01 NY)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of diabetes:

Services
Diabetes self-management education given by a **physician** (or any other licensed health care provider), including information on proper diets. Coverage is limited to visits made upon diagnosis of diabetes, where a **physician** diagnoses a significant change in the patient's symptoms or condition which requires changes in the patient's self-management, or where reeducation or refresher education is necessary.

Supplies

- Insulin;
- Insulin pumps and accessories;
- Syringes;
- Injections aids for the visually impaired;
- Test strips for glucose monitoring and visual reading and urine testing strips
- Blood glucose monitors, including those for the visually impaired
- Lancets;
- Insulin infusion devices;
- Oral agents for controlling blood sugar;
- Cartridges for the visually impaired;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.
- Any additional equipment and related supplies as may be medically necessary for the treatment of diabetes.

End of Life Care

Covered expenses include charges incurred by a covered person who has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified the patient's attending physician) for acute care services at an acute care facility specializing in the treatment of terminally ill patients. The person's attending **physician**, in consultation with the medical director of such facility, must determine that the patient's care would be appropriately provided by such facility. The facility must be licensed pursuant to New York State's public health law, or by the state in which it is located.

In the event Aetna disagrees with the admission of or provision or continuation of care of the covered person by the facility, and Aetna initiates an expedited external appeal, such admission of, provision of, or continuation of the care by the facility will not be denied, and Aetna continue to provide coverage until a decision is rendered. The decision will be binding on all parties.

Treatment of Infertility *(GR 9N 11-135 01 NY)*

Basic Infertility Services
The plan will include charges made by a **physician** to diagnose and treat a correctable medical condition where the medical condition results in **infertility**.

Comprehensive Infertility Services
The plan covers charges made for **hospital**, surgical and medical care which would correct malformation, disease or dysfunction resulting in **infertility**. The **infertility** must not be caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.

Covered expenses will include, but are not limited to, the following services or supplies:

- Ovulation induction;
- Artificial insemination;
- Ultrasound;
- Post-coital test;
- Hysterosalpinogram;
- Laparoscopy;
- Sono-hysterogram;
- Blood tests;
- Endometrial biopsy;
- Hysteroscopy;
- Semen analysis;
- Testis biopsy; and
- **Prescription** drugs

Limitations
Not covered are charges for:

- Purchases of donor sperm and any charges for the storage of any sperm;
- The purchase of donor eggs and any charges associated with care of the donor required for donor egg retrieval, transfers or gestational carriers;
- Charges associated with cryopreservation, or storage of cryopreserved embryos, including but not limited to office visits, hospital charges, ultrasounds and lab tests;
- Reversal of elective sterilization;
- Sex change procedures;
- Cloning;
- Gestational carrier programs (surrogate parenting) for you or the gestational carrier;
- Prescription drugs used for the treatment of an excluded treatment or procedure, including injectable medications;
- Home ovulation prediction kits;
- In-vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; and intracytoplasmic sperm injection;
- Frozen embryo transfers; including thawing;
- Procedures deemed experimental in accordance with the standards of the American Society for Reproductive Medicine;
- Services and supplies obtained without **precertification**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the **copays, deductibles** and maximums that apply to these services.

Spinal Manipulation Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Enteral Formulas *(GR-9N S- 11-085-NY)*

Covered expenses include charges incurred for enteral formulas for home use and modified solid food products that are low in protein or which contain protein, which are prescribed by a **physician** for the treatment of certain diseases which include, but are not limited to:

- inherited diseases of amino acid or organic acid metabolism;
- Crohn's disease;
- gastroesophageal reflux with failure to thrive;
- disorders of gastrointestinal motility;
- multiple, severe food allergies.

Transplant Services *(GR-9N-11-160-02 NY)*

Covered expenses include charges incurred during a transplant occurrence. Organ means solid organ; stem cell; bone marrow; and tissue.

Network of Transplant Specialist Facilities

Benefits may vary if an **Institute of Excellence™ (IOE)** facility or non-**IOE** or **out of network provider** is used. Through the **IOE network**, you will have access to a provider **network** that specializes in transplants. In addition, some expenses listed below are payable only within the **IOE network**. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE network** has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The **network** level of benefits is paid only for a treatment received at a facility designated by this Plan as an **IOE** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an **IOE** facility will be considered in-network care expenses.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent that it is not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered in connection with the transplant event.

For purposes of this section, the following will be considered to be one transplant occurrence:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- Services that are covered under any other part of this plan.
- Services and supplies furnished to a donor when the recipient is not a covered person.
- Home infusion therapy after the transplant occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**.

Important Reminders

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable. Transplant expenses are subject to a separate payment limit. Refer to the *Schedule of Benefits*.

Obesity Treatment

Covered expenses include charges made by a **physician**, licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and
- **Prescription drugs**.

Covered expenses include one **morbid obesity** surgical procedure, within a two-year period, beginning with the date of the first **morbid obesity** surgical procedure, unless a multi-stage procedure is planned.

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this *Booklet-Certificate*.

Important Reminder

Refer to the *Schedule of Benefits* for information about any applicable benefit maximums that apply to **morbid obesity** treatment.

Treatment of Alcoholism, Substance Abuse and Mental Disorders

Covered expenses include charges made for the treatment of alcoholism, **substance abuse** and **mental disorders** by **physicians** and **behavioral health providers**.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility.** Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder.** Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility.**

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Alcoholism and Substance Abuse *(GR 9N 11-175 01 NY)*

Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by physicians and **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse.**

Inpatient

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital** or **residential treatment facility,** appropriately licensed by the State Department of Health or its equivalent.

Coverage includes detoxification and rehabilitation services.

Outpatient Treatment

The plan covers outpatient treatment of alcoholism or **substance abuse.**

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**.

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

One day of partial confinement will count as one outpatient visit for the treatment of alcohol or substance abuse.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) *(GR-9N 11-180-01)*

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Medical Plan Exclusions *(GR-9N-28-015 01 NY)*

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet-Certificate.

Important Note:
You have medical and prescription drug and vision insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug and vision coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge,** or an **out-of-network provider** in excess of the **recognized charge**.

- Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, the shape or appearance of the body whether or not for psychological or emotional reasons, unless **medically necessary**. But this exclusion will not apply to (i) *Reconstructive Services and Specialized Care Services* under *What the Plan Covers* section; (ii) removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogentic cysts; or covered dental services or supplies to treat congenital defects or anomalies (including cleft lip or cleft palate) of covered dependent children.

Custodial Care

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Services that are not covered under this Booklet-Certificate.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Your Pharmacy Benefit *(GR-9N-S-12-005-02)*

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna prescription drug** plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet-Certificate as covered expenses that are **medically necessary.**
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this Booklet-Certificate in a safe place for future reference.

(GR-9N 12-005 01 NY)

Notice

The plan does not cover all **prescription drugs,** medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet-Certificate.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.

Getting Started: Common Terms *(GR-9N 12-010 01NY)*

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary.*

Brand-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna** or an affiliate.

Generic Prescription Drug is a **prescription drug,** whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna** or an affiliate.

Network pharmacy is a description of a **retail, mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna** for the provision of **covered services** to you and your covered dependents at a **negotiated charge.** The appropriate **pharmacy** type may also be substituted for the word **pharmacy.** (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide.**

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna** to reduce their fees and does not participate in the **Aetna** pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide.**

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs.** This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Specialty Pharmacy Network. Aetna's network of participating pharmacies designated to fill **Self-injectable Drug** prescriptions.

Accessing Pharmacies and Benefits *(GR-9N-S-12-015-01-NY)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. These **network pharmacies** have contracted with **Aetna** to provide **prescription drugs** and other supplies to you at a **negotiated charge.** You also have the choice to access state licensed **pharmacies** outside the **network** for **covered expenses.**

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits.** Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you

To better understand the choices that you have with your plan, please carefully review the following information.

Accessing Network Pharmacies and Benefits *(GR-9N 12-015 02)*

You may select a network **pharmacy** from the **Aetna** Network Pharmacy Directory or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of network **pharmacies.** If you cannot locate a network **pharmacy** in your area call Member Services.

You must present your ID card to the network **pharmacy** every time you get a **prescription** filled to be eligible for network **benefits.** The network **pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the network **pharmacy.**

Aetna will pay the network **pharmacy** the plan **coinsurance percentage** for a **covered expense,** less any cost sharing required by you. You do not have to complete or submit claim forms. The network **pharmacy** will take care of claim submission.

Emergency Prescriptions *(GR-9N-S-12-015-01-NY)*

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any **network retail pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy** you will pay the full cost of the prescription and will need to file a claim for reimbursement, you will be reimbursed for your **covered expenses** up to the cost of the prescription less any applicable cost sharing required by you.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for the **covered expense**.

When You Use an Out-of-Network Pharmacy *(GR-9N-S-12-020-01-NY) (GR-9N 13-005 01 NY)*

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits *(GR-9N-S-12-020-01-NY)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit *(GR-9N 13-005 01 NY)*

What the Plan Covers

The plan covers charges for outpatient **prescription drugs** for the treatment of an **illness** or injury, subject to the Limitations section of this coverage and the Exclusions section of the Booklet-Certificate. Prescriptions must be written by a **prescriber** licensed to prescribe federal legend prescription drugs.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** will be subject to **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your **provider** and/or **your network pharmacy**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network retail **pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a network retail **pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a network retail **pharmacy**.

All prescriptions and refills over a 30 day supply must be filled at a **mail order pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Self-Injectable Drugs - Specialty Pharmacy Network Benefits

Self-injectable drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**.

The initial prescription for a **self-injectable drug** must be filled at a **network retail pharmacy**.

You are required to obtain **self-injectable drugs** at **Aetna's specialty pharmacy network** for all prescription drug Refills of a **self-injectable drug** after the first refill must be obtained through **Aetna's specialty pharmacy network**.

To obtain a prescription through the specialty pharmacy, you or the **prescriber** must complete the Medication Request Form and fax it to the toll-free number shown on the form.

The prescription will usually be shipped by way of priority overnight service within 24 to 48 hours of receipt.

Detailed instructions for refills will be provided with the initial fill.

Other Covered Expenses *(GR-9N 13-005 01 NY)*

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use *(GR-9N 13-005 01 NY)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may be subject to **Aetna** requirements or limitations.

Diabetic Supplies *(GR-9N 13-005 01 NY)*

The following diabetic supplies upon prescription by a **physician:**

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Pharmacy Benefit Limitations *(GR-9N 13-015 01 NY)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

Pharmacy Benefit Exclusions *(GR-9N S-28-020-01 NY)*

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate . In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

- Administration or injection of any drug.
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet-Certificate.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written.

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What the Plan Covers* section.

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion will not apply to expenses incurred for enteral formulas for home use and modified solid food products that are low in protein or which contain protein, which are prescribed by a **physician** for the treatment of certain diseases which include, but are not limited to: (a) inherited diseases of amino acid or organic acid metabolism; (b) Crohn's disease; (c) gastroesophageal reflux with failure to thrive; (d) disorders of gastrointestinal motility; (e) multiple, severe food allergies.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by **Aetna**;
- Needles and syringes, except for diabetic needles and syringes;
- Unless **medically necessary**, injectable drugs if an alternative oral drug is available;

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, injectables or supplies provided through a third party vendor contract with the policyholder.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Prophylactic drugs for travel.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescriptions**.

Drugs, services and supplies provided in connection with treatment of an **occupational injury or occupational illness**.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum, unless **medically necessary**.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends *(GR-9N S-30-005-02 NY) (GR-9N 30-005-HRPA-NY)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Union Participants *(GR-9N 30-005 01 NY)*

Your coverage under the plan will end:

If the plan is discontinued;
If you voluntarily stop your coverage;
If the group policy ends;
If you are no longer eligible for coverage;
If premium payments for insurance are discontinued;
On the date you enter the armed services on an active basis;
On the date you fail to meet Continuing Eligibility requirements shown in the Booklet-Certificate;
If you become covered under another plan offered by your employer;
If you have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
If your employment stops. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, your coverage may continue until stopped by your employer as described below:

- If you are not at work due to **illness or injury**, your coverage may continue, but not beyond the end of the next policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with your employer.
- If you are not at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage *(GR-9N 30-010 01-NY)*

Under the Health Insurance Portability and Accountability Act of 1996, the Fund is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your about the certificate of **creditable coverage.**

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Union Participants (other than exhaustion of your overall maximum lifetime benefit, if included);
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent; or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by the Fund.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N 31-010 03) (GR-9N 31-015 02-NY)*

Continuing Health Care Benefits *(GR-9N 31-015 01-NY) (GR-9N DEP30)*

Continuation of Coverage

If all or a portion of your health expense coverage would terminate because you terminate employment or membership in the eligible classes, coverage (other than Dental Expense Coverage) may be continued for you and your eligible dependents. Coverage will not be continued for any person who is eligible for a like continuation under federal law.

Within 60 days of the later of:

- The date coverage would otherwise terminate; and
- The date you are sent notice by first class mail by your employer of the right to continue;

You must elect the continuation in writing and pay the first contribution. The contribution required may be up to 102% of the cost to this plan. Premium payments must be continued.

Coverage will not be continued beyond the first to occur of:

- The end of an 18 month period which starts on the date coverage would otherwise terminate.
- The end of a 29 month period which starts on the date your coverage would otherwise terminate; but only if, prior to the end of the above 18 months period, you provide notice to your employer that you have been determined to be disabled under Title II or XVI of the Social Security Act on the date your coverage would have otherwise terminated, except for this continuation. If you are no longer determined to be so disabled, you must notify your employer within 30 days of such determination. In that case, coverage will cease at the start of the month that begins more than 31 days after the date of the final determination that you are no longer so disabled.
- The date you become eligible for like group coverage, including coverage for any preexisting condition.
- The end of the period for which any required contributions have been made.
- Discontinuance of the coverage involved as to Union Participants of the eligible class of which you were a member.
- The date you become enrolled in benefits under Medicare.

Coverage for a dependent may not be continued beyond the date it would otherwise terminate.

If any coverage being continued ceases, you may apply for a conversion policy. See *Converting to an Individual Health Policy.*

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N-31-015-05 NY)*

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify the Fund as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children *(GR-9N 31-015 01-NY)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

COBRA Continuation of Coverage *(GR-9N 31-025 NY)*

If the Fund is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, the Fund will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of the Fund's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former Fund files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify the Fund within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the Fund within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- The Fund is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date the Fund no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by the Fund. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact the Fund or call the toll-free number on your member ID card.

Converting to an Individual Medical Insurance Policy

Eligibility

You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by **Aetna** when you or your dependents apply under the Fund's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

If the plan does not include major medical benefits, coverage may be elected under one of the following plans:

- Plan I: Hospital room and board expense benefits of $130 per day. The maximum duration is 30 days. Miscellaneous hospital expense benefits to a maximum of $1,300. Surgical operation expense benefits according to a $1,400 maximum benefits schedule.
- Plan II: Hospital room and board expense benefits of $230 per day. The maximum duration is 30 days. Miscellaneous hospital expense benefits to a maximum of $2,300. Surgical operation expense benefits according to a $2,400 maximum benefits schedule.
- Plan III: Hospital room and board expense benefits of $330 per day. The maximum duration is 70 days. Miscellaneous hospital expense benefits to a maximum of $3,300. Surgical operation expense benefits according to a $3,500 maximum benefits schedule.

If the plan includes only major medical benefits, coverage may be elected under the following plan only:

- Plan IV: Major medical expense benefits providing: (a) a $330 per day hospital room and board benefit; (b) surgical expense benefits according to a $4,500 maximum benefits schedule; (c) a $200,000 maximum benefit for all sicknesses and injuries; (d) a deductible of $1,000; (e) an 80% benefit percentage, with a coinsurance limit of $2,000; and (f) an annual restoration benefit of $5,000.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy;
- Require a statement that **Aetna** may ask for data about your coverage under any other plan. This may be asked for on any premium due date for the individual policy. If you do not give the data, expenses covered under the individual policy may be reduced by expenses which are covered or provided under those plans.

Limitations

You or your dependents do not have a right to convert if:

- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.

- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 45 days after your coverage ends. The 45 days start on the date group coverage ceases. The application period will be extended for 45 days from the date the Fund gives you written notice of the conversion privilege, as required by law, but not beyond 90 days from the date group coverage ceases.

If coverage ends because of retirement, the 45 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from the Fund.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Coordination of Benefits - What Happens When There is More Than One Health Plan

(GR-9N 33-005-01-NY)

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. "Plan" and "This plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room (unless the patient's stay in the private room is medically necessary in terms of generally accepted medical practices, or one of the Plans routinely provides coverage of hospital private rooms) is not an allowable expense.

If a person is covered by one Plan that computes its benefit payments on the basis of recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or Union Participant benefit organization plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First *(GR-9N 33-010 01 NY)*

To find out whether the regular benefits under this plan will be reduced, the order in which the various plans will pay benefits must first be figured. This will be done as follows:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- A plan which covers a person as other than a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent.

1. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers a person as a dependent of a person whose birthday comes later in the year; however:
   (a) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
   (b) if the other plan does not have the rules described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefit, the rule in the other plan will determine the order of benefits.

2. In the case of a dependent child whose parents are divorces or separated:
   (a) If there is a court decree which makes one parent financially responsible for the health care expenses with respect to the child and the entity obligated to pay or provide the benefits of that parent has actual knowledge of those terms, the benefits of that plan which covers the child as a dependent of such parent shall be determined before the benefits of any other plan which covers the child as a dependent child.
   (b) If there is no such court decree, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the **custodial parent;**
      - The plan of the non**custodial parent**; and then
3. Active Union Participant or Retired or Laid off Union Participant. The plan that covers a person as an Union Participant who is neither laid off nor retired or as a dependent of an active Union Participant, is the primary plan. The plan covering that same person as a retired or laid off Union Participant or as a dependent of a retired or laid off Union Participant is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Longer or Shorter Length of Coverage. The plan that covered the person as an Union Participant, member, subscriber longer is primary.
5. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the **secondary plan** will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any **allowable expense** under this plan that was unpaid by the **primary plan.** The amount will be reduced so that when combined with the amount paid by the **primary plan,** the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total **allowable expense.**

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **This Plan,** the amount normally reimbursed for covered benefits or expenses under **This Plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **This Plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **This Plan** and another plan both agree that **This Plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plans** COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

(GR-9N 33-020-01)

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare.**

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**

You are eligible for **Medicare** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare.**

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan's** benefits is based on current employment with the Fund. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare:**

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more Union Participants);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan's** benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of a Fund with 100 or more Union Participants).

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

- If the result is more than the benefit paid by **Medicare**, the **plan** will pay the difference, up to 100% of plan expenses. Plan expenses are any **medically necessary** health expenses which are covered, in whole or in part, under the plan.
- If the result is less than the benefit paid by **Medicare**, the **plan** will not pay a benefit, except as required by law.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-9N-S-33-025-01)*

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions

(GR-9N-32-005-02-NY)

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact the Fund or **Aetna**.
- The Fund hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this group insurance policy.

Misstatements

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible Union participant or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Subrogation and Right of Reimbursement

As used herein, the term "**Third Party**", means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as "**Third Party Injuries.**" "**Third Party**" includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries.**

If this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are (a) associated with the **Third Party Injuries;** and (b) specifically identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment or compensation agreement. **Aetna**'s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence.

By accepting benefits under this plan, you specifically acknowledge **Aetna**'s right of subrogation. In the event you suffer injuries for which a **Third Party** is responsible (such as someone injuring you in an accident), and **Aetna** pays benefits as a result of those injuries, **Aetna** will be subrogated and succeed to the right of recovery against such **Third Party** to the extent of the benefits **Aetna** has paid. This means that **Aetna** has the right, independently of you, to proceed against the **Third Party** responsible for your injuries to recover the benefits **Aetna** has paid.

By accepting benefits under this plan, you also specifically acknowledge **Aetna**'s right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party**. By providing any benefit under this Booklet-Certificate, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan, but only to the extent such benefits are identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment or compensation agreement. **Aetna**'s right of reimbursement is cumulative with and not exclusive of **Aetna**'s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**'s rights of subrogation and reimbursement under this Booklet-Certificate;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (but only to the extent such benefits are identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (but only to the extent such benefits are identified or allocated as payments previously made by **Aetna** for such injuries in any recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this Booklet-Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna**'s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**.

Worker's Compensation

If benefits are paid by **Aetna** and **Aetna** determines you received Worker's Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna** will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify **Aetna** of any Worker's Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments *(GR-9N-S-30-015-01)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Reporting of Claims *(GR-9N-S-30-015-01)*

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. the Fund has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible.

Payment of Benefits *(GR-9N 32-025 02-NY)*

Benefits will be paid as soon as the necessary proof to support the claim is received, but not later than 45 days after receipt of such proof. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** (**network services or supplies**), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses *(GR-9N-32-030-02)*

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by the Fund, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by the Fund (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

health coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence.*

Glossary *

(GR-9N 34-005 01-NY)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N 34-010 01-NY) (GR-9N 34-005 02)*

Accident *(GR-9N 34-005 01-NY)*

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

Aetna Life Insurance Company.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B *(GR-9N 34-010 01-NY) (GR-9N 34-005 01-NY)*

Behavioral Health Provider

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorders** acting within the scope of the applicable license. This includes:

- **Hospitals;**
- Psychiatric **hospitals;**
- **Residential treatment facilities;**
- **Psychiatric physicians;**
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists; and
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Birthing Center

A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C *(CR-9N 34-015 02)*

Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

Coinsurance Limit

Coinsurance limit is the maximum out-of-pocket amount you are responsible to pay for **coinsurance** for **covered expenses** during your calendar year. Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. The **coinsurance limit** applies to both network and out-of-network benefits.

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service or tribal organization;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
This means services and supplies that are primarily intended to help you meet personal needs, such as transferring, eating, dressing, bathing, toileting and such other related activities. This includes board and room and other institutional care. You do not have to be disabled. Such services and supplies are **custodial care** without regard to:

- by whom they are prescribed;
- by whom they are recommended; or
- by whom they are performed.

D *(GR-9N 34-020 01) (GR-9N S-34-095-01-NY)*

Day Care Treatment
A **partial confinement treatment** program to provide treatment for you during the day. The **hospital, psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible
The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits.*

Deductible Carryover
This allows you to apply any **covered expense** incurred during the last 3 months of a calendar year that is applied toward this year's **deductible** to also apply toward the following year's **deductible.**

Dentist
A legally qualified **dentist,** or a **physician** licensed to do the dental work he or she performs.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of Union Participants to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have a **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E *(GR-9N 34-025 01 NY)*

Effective Treatment of a Mental Disorder

This is a program that:

- Is prescribed; and supervised; by a **physician**; and
- Is for a **mental disorder** that can be favorably changed.

Emergency Medical Condition

A recent and severe medical or behavioral condition, the onset of which is sudden, manifests itself by symptoms of sufficient severity, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- In the case of a behavioral condition, placing the health of such person, or others', in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious disfigurement of such person; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

G *(GR-9N 34-035 01)*

Generic Prescription Drug

A **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna** or an affiliate.

H *(GR-9N 34-040 02)*

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital

This means a short-term, acute, general hospital which:

- Is primarily engaged in providing, by or under the continuous supervision of **physicians**, to inpatients, diagnostic services and therapeutic services for diagnostic, treatment and care of injured and sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a **physician** or dentist;
- Provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861k of U.S. Public Law 89-97 (42 USCA 1395x(k));
- Is duly licensed by the agency responsible for licensing such hospitals;
- Makes charges; and
- Is not, other than incidentally, a place for rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I *(GR-9N 34-045 02)*

Illness *(GR-9N 34-045 02)*

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is 21 or more but less than 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older, but less than 45*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to furnish services or supplies to an **IOE** patient in connection with specific transplants at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants for which it has signed a contract.

J *(GR-9N 34-050 01)*

Jaw Joint Disorder *(GR-9N 34-050 01)*
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L *(GR-9N 34-055 01)*

Late Enrollee
This is an Union participant in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the Union participant did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible Union participant or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet-Certificate.

Lifetime Maximum
This is the most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime.

L.P.N.
A licensed practical or vocational nurse.

M *(GR-9N 34-065 04)*

Mail Order Pharmacy
An establishment where **prescription drugs** are legally dispensed by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary or Medical Necessity

Health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that provision of the service, supply or **prescription drug** is:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
c) Not primarily for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

- Alcoholism and substance abuse.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Psychotic depression.
- Schizophrenia.

For the purposes of benefits under this plan, **mental disorder** will include alcoholism and substance abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and substance abuse.

N *(GR-9N 34-070 02)*

Negotiated Charge

The maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan. The **negotiated charge** does not include or reflect any amount **Aetna** or an affiliate may receive under a rebate arrangement between **Aetna** or an affiliate and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology (ART)** services.

Network Provider

A health care provider or **pharmacy** who has contracted to furnish services or supplies for a **negotiated charge**; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of Union participants to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)

A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist

A **physician** who is not a **specialist**.

Non-Urgent Admission

An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O *(GR-9N-34-065 01-NY) (GR-9N 34-075 01)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Out-of-Network Service(s) and Supply(ies) *(GR-9N 34-075 01)*
Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider
A health care provider or **pharmacy** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

P *(GR-9N 34-080 01-NY) (GR-9N 34-070-01)*

Pharmacy
An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Drug Guide

A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.Aetna.com/formulary.

Preferred Drug Guide Exclusions List

A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna.**

Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders.**
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician.**
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders.**

R *(GR-9N 34-090 02)*

Recognized Charge

Only that part of a charge which is less than or equal to the **recognized charge** is a **covered benefit.** The **recognized charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge **Aetna** determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
  a. For non-facility charges: **Aetna** uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
  b. For facility charges: **Aetna** uses the **Aetna** Facility Fee Schedule for the geographic area where the service is furnished.
- For **prescription drugs:** 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current **average wholesale price** of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna** on the day that a **pharmacy** claim is submitted for adjudication.

In determining the **recognized charge** for a service or supply that is:

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of **providers** in the geographic area;

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the **provider**;
- The range of services or supplies provided by a facility; and
- The **recognized charge** in other geographic areas.

In some circumstances, **Aetna** may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.

As used above, the term "geographic area" means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Alcoholism and Substance Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours perday/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- Has, on-site licensed **Behavioral Health Provider** 24 hours per day.
- Provides a comprehensive patient assessment.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions.
- Has the ability to involve family/support systems in therapy.
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Is managed by a licensed **Behavioral Health Provider** who functions under the direction and supervision of a **psychiatric physician**.
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Provides active discharge planning initiated upon admission to the program.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.

R.N.

A registered nurse.

Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S *(GR-9N 34-095-02) (GR-9N 34-090 01-NY)*

Self-injectable Drug(s)

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorders**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services.**

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders.**

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care

Health care services or supplies that require the services of a **specialist.**

Specialty Pharmacy Network

A network of pharmacies designated to fill **self-injectable drug prescriptions.**

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy
Procedures under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Substance Abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions.**

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- **Physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T *(GR-9N-S-34-095-01-NY) (GR-9N-34-100-02)*

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 6 months or less to live.

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U *(GR-9N-S-34-105-01)*

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in a **illness**; or
- The diagnosis of a **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.
- It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden **illness**; **injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Additional Information Provided by

Laborers Local No. 754 Joint Benefit Funds

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Open Access Managed Choice

Policyholder Identification Number:
13-1895923

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Laborers Local No. 754 Joint Benefit Funds
215 Old Nyack Turnpike
Chestnut Ridge, NY 10977
Telephone Number: (845)245-0210

Agent For Service of Legal Process:
Laborers Local No. 754 Joint Benefit Funds
215 Old Nyack Turnpike
Chestnut Ridge, NY 10977

Service of legal process may also be made upon the Plan Administrator

End of Policy Year:
The last day in February

Source of Contributions:
Paid by Union Participants

Procedure for Amending the Plan:
The Fund may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

The Plan is maintained in accordance with health and welfare provisions of a collective bargaining agreement.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Union participant benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including the Fund, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp#TopOfPage, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If the Fund grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and the Fund.

If your Fund grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by the Fund to continue coverage. The Fund must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date the Fund determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by the Fund.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by the Fund, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date the Fund determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date the Fund determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date the Fund determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because the Fund determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date the Fund determines the approved FMLA leave is terminated.

Schedule of Benefits

(GR-29N 01-01 01)

Fund:	**Laborers Local No. 754 Joint Benefits Funds**
Group Policy Number:	**GP-475051**
Issue Date:	July 8, 2010
Effective Date:	March 1, 2009
Schedule:	5A
Cert Base:	5

For: Open Access Managed Choice- Active Union participants located in New York, Florida, New Jersey, Pennsylvania, West Virginia, Kentucky, Louisiana, Minnesota, Georgia or Texas

This is an ERISA plan, and you have certain rights under this plan. Please contact your Fund for additional information.

Gatekeeper PPO Medical Plan *(GR-9N 11-005 01 NY)*

Calendar Year Deductible*		
Individual Deductible*	**$500**	**$1,000**
Family Deductible*	**$1,000**	**$2,000**

Plan Coinsurance Limit excludes plan **deductible and copayments** .

Individual Coinsurance Limit:

- For **network** expenses: $3,000.
- For **out-of-network** expenses: $10,000.

Family Coinsurance Limit:

- For **network** expenses: $6,000.
- For **out-of-network** expenses: $20,000.

Calendar Year Maximum Benefit per Person	$250,000	$250,000
Lifetime Maximum Benefit per person	Unlimited	Unlimited

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.
All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

Wellness Benefit		
Routine Physical Exams Adults and Children age 19 and over Includes coverage for immunizations.	$25 exam copay then the plan pays 100% No deductible applies.	60% per exam after Calendar year deductible
Maximum Exams per unlimited consecutive month period		
Adults age 19 to 65	1 exam	1 exam
Maximum Exams per 12 consecutive month period		
Adults age 65 and over	1 exam	1 exam
Preventative Care Services	100% per exam No deductible applies.	60% per exam after Calendar Year deductible
Hearing Exam (GR-9N-1-11-010-01)	$25 exam copay then the plan pays 100% No deductible applies.	60% per exam after Calendar Year deductible
Maximum exams per 24 month period	1 exam	1 exam

Routine Cancer Screenings (age and maximum limits do not apply to any person at high risk for the cancer being screened)		
Routine Mammography	100% per test No deductible applies.	60% per test after Calendar Year deductible.
Diagnostic Screening for Prostatic Cancer	100% per test No deductible applies.	60% per test after Calendar Year deductible.
Maximum tests per Calendar Year		
Prostate Specific Antigen Test (PSA)	1 test	1 test
Digital Rectal Exam (DRE)	1 test	1 test
Bone Mineral Density Measurements or Tests	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Gynecological Exams Including Pap Smears	100% per test after $25 copay No deductible applies.	60% per test after Calendar Year deductible.
Maximum tests per Calendar Year	2 tests	2 tests
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test

Double Contrast Barium Enema (DCBE) Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 10 consecutive year period	1 test	1 test
Family Planning Services		
Family Planning Services	100% per visit after office visit copay for services in a physicians office. No deductible applies.	60% per visit after Calendar Year deductible
Vision Care		
Eye Examinations including refraction	$25 exam copay then the plan pays 100% No deductible applies.	60% per exam after Calendar Year deductible
Maximum Benefit per 24 consecutive month period	1 exam	1 exam
Vision Care Supplies	80% after Calendar year deductible	60% after calendar year deductible
Maximum Benefit for All Vision Care Supplies per 24 consecutive month period. (Does not apply toward the plan's lifetime maximum)	$100	

Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	$25 visit copay then the plan pays 100% No deductible applies.	60% per visit after Calendar Year deductible
Alternatives to Physicians' Office Visits		
E-Visit Online Internet Consultation by a PCP	$25 visit copay then the plan pays 100% No deductible applies.	Not Covered
Specialist Office Visits	$25 visit copay after Calendar Year deductible then the plan pays 80%	60% per visit after Calendar Year deductible
Alternative to Specialist Office Visit		
E-visits Online Internet Consultation by a Specialist	$25 visit copay then the plan pays 100% No deductible applies.	Not Covered
Physician Office Visits-Surgery		
Physician	$25 per visit copay after Calendar Year deductible then the plan pays 80%	60% per visit after Calendar Year deductible
Specialist	$25 per visit copay after Calendar Year deductible then the plan pays 80%	60% per visit after Calendar Year deductible
Walk-In Clinics Non-Emergency Visit (GR-9N-10-025 01 NY)	$25 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

Administration of Anesthesia	80% per procedure after Calendar Year deductible.	60% per procedure after Calendar Year deductible.
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Allergy Injections	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.
Immunizations (when not part of the physical exam)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Emergency Medical Services		
Hospital Emergency Facility	80% per visit	80% per visit
Non-Emergency Care in a Hospital Emergency Room	80% after Calendar Year deductible	60% after Calendar Year deductible
Urgent Care Services		
Urgent Medical Care (at a non-hospital free standing facility)	80% after Calendar Year deductible	60% after Calendar Year deductible
Urgent Medical Care (from other than a non-hospital free standing facility)	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider (at an Emergency Room or a non-hospital free standing facility)	Not covered	Not covered

Outpatient Diagnostic Lab and Radiologic Services and Preoperative Testing		
Outpatient Diagnostic Lab and Radiologic Services and Preoperative Testing	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible
Outpatient Surgery		
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Expenses Room and Board (including maternity)	80% per admission after Calendar Year deductible	$100 per continuous admission deductible after Calendar Year deductible then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Skilled Nursing Facility	80% per admission after Calendar Year deductible	$100 per continuous admission deductible after Calendar Year deductible then the plan pays 60%
Maximum Days per Calendar Year	60 days	60 days
Ambulatory Care Cancer	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Specialty Benefits		
Home Health Care (Outpatient)	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	120 visits	120 visits

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Maximum Benefit per lifetime	30 days	30 days
Hospice Outpatient Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Maximum Benefit per lifetime, inpatient and outpatient combined	180 days	180 days
Bereavement Counseling Maximum	5 visits	5 visits

Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of a correctable medical condition causing the infertility.	Payable on the same basis as any other illness or injury, in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Payable on the same basis as any other illness or injury, in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.
Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Inpatient Treatment of Mental Disorders		
Coverage for Biologically-Based Mental Illness and Children with serious Emotional Disturbances		
Inpatient	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.
Coverage for other than Biologically-Based Mental Illness and Children with Serious Emotional Disturbances		
Inpatient	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible
Maximum Benefit per Calendar Year	30 days	30 days

Outpatient Treatment Of Mental Disorders		
Coverage for Biologically-Based Mental Illness and Children with serious Emotional Disturbances		
Outpatient	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.
Coverage for other than Biologically-Based Mental Illness and Children with Serious Emotional Disturbances		
Outpatient	$25 per visit copay after Calendar Year deductible then the plan pays 80%	60% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	30 visits	30 visits

Inpatient Treatment of Alcoholism and Substance Abuse		
Inpatient Treatment	80% per admission after Calendar Year deductible.	60% per admission after Calendar Year deductible.
Maximum Days per Calendar Year	30 days.	30 days.
Outpatient Treatment of Alcoholism and Substance Abuse		
Outpatient Treatment	$25 per visit copay after Calendar year deductible then the plan pays 80%.	80% per visit after Calendar Year deductible.
Maximum Visits per Calendar Year	60 visits, at least 20 for family members.	60 visits, at least 20 for family members.
Transplant Services Facility and Non-Facility Expenses		
Facility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Other Covered Health Expenses		
Acupuncture In lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Emergency Transport (Air, Water, Ground)	80% per trip after Calendar Year deductible.	60% per trip after Calendar Year deductible.
Non-Emergency Transportation (ground)	80% per trip after Calendar Year deductible.	60% per trip after Calendar Year deductible.
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	80% per item after the Calendar Year deductible.	60% per item after the Calendar Year deductible.
(GR-9N-5-11-080 01 NY) (GR-9N-5-11-080 01 NY)		
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Enteral Formula	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maternity Expenses	Payable on the same basis as any other illness or injury, in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Payable on the same basis as any other illness or injury, in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.
Reconstructive Surgery and Supplies	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Reconstructive Breast Surgery	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
End of Life Care	Payable on the same basis as any other illness or injury, in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Payable on the same basis as any other illness or injury, in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational and Speech Therapy combined	$25 per visit copay after Calendar Year deductible then the plan pays 100%	60% per visit after Calendar Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits
Speech Loss and Impairment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Early Intervention Services	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Services Provided by a Center for Eating Disorders	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Second Medical Opinions		
Second Medical Opinions (by an appropriate specialist (including, but not limited to a specialist affiliated with a specialty care center for the treatment of cancer) in the event of a positive or negative diagnosis of cancer, or a recurrence of cancer, or a recommendation of a course of treatment for cancer)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Second Opinions	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Pharmacy Benefit *(GR-9N-S-26-005-01)*

Copays/Deductibles *(GR-9N-S-26-010-01 NY)*

Generic Prescription Drugs		
For each 30 day supply	$25	None
For more than a 30 day supply but less than a 91 day supply	$50	Not Applicable

Brand-Name Prescription Drugs		
For each 30 day supply	$35	None
For more than a 30 day supply but less than a 91 day supply	$70	Not Applicable

Coinsurance

Prescription Drug Plan Coinsurance	**100% of the negotiated charge**	**60% of the reasonable charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Expense Provisions *(GR-9N S-09-05-01 NY)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits.*

The insurance described in this *Schedule of Benefits* is underwritten by Aetna Life Insurance Company, policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions *(GR-9N S-09-05-01 NY)*

Network Calendar Year Deductible
This is an amount of **network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible
This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible.**

Network Family Deductible Limit
When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Out-of-Network Family Deductible Limit
When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network Calendar Year** family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

Copayments and Benefit Deductible Provisions *(GR-9N S-09-15-01 NY)*

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Coinsurance Limit
The **Coinsurance Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Coinsurance Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Coinsurance Limit** applies to both network and out-of-network benefits.

This plan has an Individual **Coinsurance Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Coinsurance Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Coinsurance Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the Family **Coinsurance Limit** amount in the *Schedule of Benefits*, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

The **Coinsurance Limit** applies to both network and out -of-network benefits. **Covered expenses** applied to the out-of-network **Coinsurance Limit** will be applied to satisfy the in-network **Coinsurance Limit** and **covered expenses** applied to the in-network **Coinsurance Limit** will be applied to satisfy the out-of-network **Coinsurance Limit**.

Expenses That Do Not Apply to Your Coinsurance Limit
Certain covered expenses do not apply toward your plan **coinsurance** limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*); and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions *(GR-9N S-09-025 01)*

Calendar Year Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

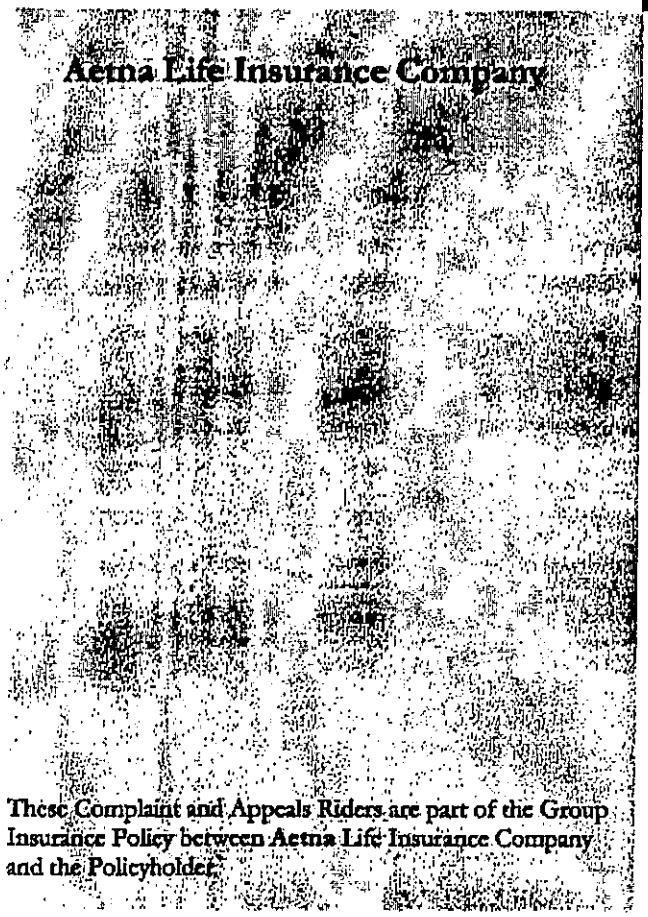
General *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.

BENEFIT PLAN

Prepared Exclusively for
Laborers Local No. 754 Joint Benefit Funds

Complaint and Appeals Riders



These Complaint and Appeals Riders are part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder.

Complaint and Appeals Riders

We want you to know℠

Aetna®

Table of Contents

Complaint and Appeals Rider Included in this document

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-9N-Appeals 01-01 01 1_A)*

Policyholder:	475051
Group Policy No.:	475051
Rider:	Louisiana Complaint and Appeals Health Rider
Issue Date:	July 1, 2010
Effective Date:	March 1, 2009

Complaint and Appeals - Health Coverage

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: A written request to Aetna to reconsider an **adverse benefit determination**.

Business Day: Monday through Friday (excluding holidays and days upon which Aetna is unable to conduct business in a normal manner due to an emergency situation declared by state or local government authorities).

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Claim Determinations *(GR-9N-Appeals 01-02 01 1A)*

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make a claim determination as soon as possible, but not later than 2 **business days** after a **pre-service claim** request, provided that Aetna has received all appropriate medical information. Aetna will make notification of a claim determination to the provider rendering the service not later than 1 **business day** after the claim determination has been made. Aetna will provide written confirmation of such notification within 2 **business days** of making the claim determination.

If an extension is required because Aetna needs additional information to make a claim determination, the covered person will receive a notice of the extension. The notice shall specifically describe the required information. In no event will the extension period exceed 30 **business days** from the date of the **pre-service claim** request unless you or the provider has agreed to the extension period.

Post-Service Claims

Aetna will make a claim determination as soon as possible, but not later than 30 **business days** after a **post-service claim** request, provided that Aetna has received all appropriate medical information. Aetna will make notification of a claim determination to the provider rendering the service not later than 5 **business days** after the claim determination is made.

If an extension is required because Aetna needs additional information to make a claim determination, the covered person will receive a notice of the extension. The notice shall specifically describe the required information. In no event will the extension period exceed 180 calendar days from the date of the **post-service claim** request.

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:

- coverage was terminated due to fraud or non-payment of premiums; or
- the approval was based upon a material omission or misrepresentation of the person's health condition by the provider.

Concurrent Care Claim Extension

Aetna will make a claim determination as soon as possible, but not later than 1 **business day** after a **concurrent care claim extension** request, provided that Aetna has received all appropriate medical information.

In the case of a **concurrent care claim extension** request approval, Aetna will provide notification of a claim determination to the provider rendering the service not later than 1 **business day** after the claim determination has been made. Aetna will make written confirmation of such notification within 2 **business days** after the claim determination.

In the case of an **adverse benefit determination,** Aetna will provide notification to the provider rendering the service not later than 1 **business day** after the claim determination has been made. Aetna will make written confirmation of such notification within 1 **business day** of providing notification. The service or supply will be continued without liability to the provider or the person (subject to the terms of the Policy) until the provider receives notice of Aetna's decision.

Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal.**

Complaints *(GR-9N-Appeals 01-05 01)*

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations *(GR-9N-Appeals 01-06 01 1-A)*

Informal Process

As to an **adverse benefit determination** involving a group health claim, the provider rendering the service that was denied may request, on your behalf and within 10 calendar days following the date of the notice of the **adverse benefit determination,** an informal reconsideration of the claim determination. The informal reconsideration will be completed within 1 **business day** of Aetna receiving the request from the provider and will be conducted between the provider and the Aetna Medical Director involved in making the **adverse benefit determination.** If the Medical Director is not available then the Medical Director may designate a clinical peer in his or her place.

In the event that the informal reconsideration does not resolve the differences of opinion to your satisfaction, then the **adverse benefit determination** may be appealed as described below in the Formal Process.

Formal Process

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination.** This Plan provides for two levels of **appeal.** It will also provide an option to request an external review of the **adverse benefit determination.**

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal.** Your **appeal** may be submitted in writing and should include:

- Your name;
- The fund's name;
- A copy of Aetna's notice of an **adverse benefit determination;**
- Your reasons for making the **appeal;** and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID Card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to Aetna.

Level One Appeal *(GR-9N-Appeals 01-07 01 LA)*
A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not involved in making the **adverse benefit determination**.

Urgent care claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal.**

Pre-Service claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 15 **business days** of receipt of the request for an **appeal.**

Post-Service Claims
Aetna shall issue a decision within 30 **business days** of receipt of the request for an **appeal.**

A duly licensed **physician** must concur with an **adverse benefit determination** that is upheld. The contents of the written decision will comply with any applicable state law.

Level Two Appeal
If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the adverse determination was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal.**

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim** shall be provided by Aetna personnel not involved in making an **adverse benefit determination.** A level two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the Aetna Appeals Committee.

The Level Two Appeal review will occur within 45 days of Aetna receiving a request for a Level Two **Appeal.** You have the right to attend the Level Two **Appeal** review and will be notified of your rights at least 15 **business days** in advance of the date of the review. The contents of the notice will comply with any applicable state law. If you cannot attend the review, you may participate by conference call or other available technology. you may also request that Aetna consider postponement and re-scheduling of the hearing.

If requested, Aetna will provide you with all relevant information regarding your **appeal** that is not confidential or privileged.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the conclusion of the Level Two **appeal** review.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 5 **business days** of the date of the Level Two **appeal** review.

Post-Service Claims
Aetna shall issue a decision within 5 **business days** of the date of the Level Two **appeal** review.

A duly licensed and appropriate clinical peer must concur with any **adverse benefit determination** that is upheld. The contents of the written decision will comply with any applicable state law including information on your right to request an External Review.

Exhaustion of Process *(GR-9N-Appeals 01-10 01 1_A)*

Aetna encourages you to exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- contact the Louisiana Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- file a complaint or **appeal** with the Louisiana Department of Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

External Review *(GR-9N-Appeals 01-11 01 1_A)*

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is **experimental or investigational** in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician**, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not **necessary** or was **experimental** or **investigational**; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal **appeal** processes.

You do not have to exhaust the internal **appeals** procedure to request an external review if:

- Aetna agrees to waive the internal **appeals** procedure for the Level One, Level Two Appeal or both; or
- your treating **physician** has certified in writing that you have an **emergency condition**.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select a **physician reviewer** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the requested service or supply would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Aetna's External Review program, call the toll-free Customer Services telephone number shown on your ID card.

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-9N-Appeals 01-01 01)*

Policyholder:	475051
Group Policy No.:	GP-475051
Rider:	New York Complaint and Appeals Health Rider
Issue Date:	July 1, 2010
Effective Date:	March 1, 2009

Complaint and Appeals - Health Coverage

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

Appeals Procedure

Definitions

Adverse benefit determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit because it is determined to be experimental or investigational or not medically necessary or appropriate.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage ;
- The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **medically necessary**, based on the information provided).

If applicable, denials of out-of-network claims on the basis that an out-of-network service is not materially different than an in-network service shall not constitute an **adverse benefit determination.**

Appeal: An oral or written request to Aetna to reconsider an **adverse benefit determination.**

Health care provider: A health care professional or facility licensed pursuant to New York law or licensed, registered or certified by another state.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment or provide additional services.

Expedited Appeal: Appeal of an **adverse benefit determination** involving (1) continued or extended health care services, procedures and treatments or additional services for a covered person undergoing a course of continued treatment prescribed by a health care provider, or (2) an **adverse benefit determination** in which the health care provider believes an immediate appeal is warranted where there is imminent or serious threat to the health of the insured, except any retrospective determination.

Grievance: A request for review of a determination, other than a determination meeting the definition of **adverse benefit determination.**

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Concurrent Care Claim Extension," an "Urgent Care Claim" or a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the person or the ability of the person to regain maximum function; or (b) in the opinion of a physician with knowledge of the person's medical condition would subject the person to severe pain that cannot be adequately managed without the requested treatment.

Out-of-Network Denial: A denial of a request for preauthorization to receive a health service from an out-of-network provider on the basis that such service is not materially different from a health service available in-network. The Notice of denial of such out-of-network service shall include information explaining what information must be submitted to appeal the denial.

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of a claim determination as soon as possible, but not later than 72 hours after receipt of the necessary information.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days. Aetna will notify you or your designee and your **Health Care Provider** of the determination by telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension,** Aetna will make notification of a claim determination by telephone and in writing to you, your designee and your **health care provider** as soon as possible, but no later than 24 hours after receipt of the necessary information.

Post-service Claims

Aetna will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days.

The Notice of **adverse benefit determination** will include:

- The reasons for the **adverse benefit determination,** including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the plan's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions on how to start the appeals, expedited appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse**
- **benefit determination.** This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on **appeal.**

In the event that Aetna renders an **adverse benefit determination** without first attempting to discuss the matter with the insured's **health care provider** who specifically recommended the service, procedure or treatment, the **health care provider** will have the opportunity to request a reconsideration of the adverse benefit determination. Except for post-service claims, such reconsideration will occur within
one business day of receipt by Aetna of the request. If the **adverse benefit determination** is upheld, Aetna will provide notice, as described above.

If Aetna does not render a decision within the period set forth above, you may consider this to be an **adverse benefit determination**, subject to **appeal**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an **in-network provider (if applicable)** you must call or write Aetna Customer Service. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 15 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

By calling Customer Service. Aetna's Customer Service telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

Appeals of Out-of-Network Denials (if applicable)

You may appeal an out-of-network denial based on the fact that an alternate service is available in-network by submitting:

- a written statement from your **physician** that the service is materially different from the health service the plan approved to treat your medical needs
- two documents from available medical and scientific evidence, stating that such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination.** This Plan provides for 1two levels of **appeal.** 2It will also provide an option to request an external review of the **adverse benefit determination.**

You have 180 calendar days with respect to Group Health and Group Disability claims and 60 calendar days with respect to all Other Group claims following the receipt of notice of an **adverse benefit determination** to request your 1level one **appeal.** Your **appeal** may be submitted orally or in writing. The request should include:

Your name;
The fund's name;
A statement from your physician;
A copy of Aetna's notice of an **adverse benefit determination;**
Your reasons for making the **appeal;** and
Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID Card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

You may also choose to have an authorized designee make the **appeal** on your behalf by providing written consent to Aetna. Your **health care provider** may make the appeal in connection with the **adverse benefit determination** for a **post service claim.**

Level One Appeal – Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be decided by Aetna personnel not involved in making the **adverse benefit determination.**

Expedited Appeals

Aetna has established an expedited **appeals** process for adverse **benefit determinations** involving **urgent care** claims, **concurrent care claim extensions** and **pre-service claims.** Aetna will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within 36 hours of receipt of the necessary information to conduct the **appeal.**

Standard Appeals

Aetna shall issue a decision within 30 calendar days of receipt of the necessary information to conduct the **appeal.** Aetna will provide written acknowledgement of the filing of the **appeal** within 15 days of its receipt.

The notice of the appeal determination will include:

- If the **adverse benefit determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of your right to an external appeal, together with information and a description of the external **appeals** process. You also have the option to request a Level 2 **appeal** from Aetna.

If Aetna does not render an appeals determination within 60 days after receipt if the information necessary to conduct the appeal, the adverse benefit determination will be reversed.

Level Two Appeal

If Aetna upholds an **adverse benefit determination** at the first level of **appeal,** you or your authorized representative have the option to file a level two **appeal** or request an External Appeal. The Level Two **appeal,** if requested, must be submitted within 60 calendar days following the receipt of notice of a level one **appeal** determination.

A level two **appeal** of an **adverse benefit determination** of an **expedited appeal** shall be decided by Aetna personnel not involved in making the **adverse benefit determination.** A level two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the Aetna Appeals Committee.

Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)

Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal** for these claims.

Pre-Service Claims (other than those subject to an Expedited Appeal)

Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal.**

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal.**

Grievances

You may submit a **grievance** to Aetna with respect to review of any determination other than an **adverse benefit determination.**

Aetna will acknowledge receipt of the **grievance** within 15 calendar days after its receipt by Aetna.

Grievance Determinations
Expedited Grievances
Aetna will resolve an expedited **grievance** within 36 hours after receipt of all necessary information when delay would significantly increase the risk to a person's health.

Standard Grievances
For other **grievances**, Aetna will acknowledge receipt within 15 calendar days and issue a determination within 30 calendar days after receipt of the **grievance**, but not later than 45 days after receipt of all necessary information.

Grievance Appeals
Expedited Grievances
Aetna will render a decision within 36 hours after receipt of the appeal.

Standard Grievances
Aetna will acknowledge receipt within 15 calendar days and issue a determination within 30 calendar days after receipt of the appeal.

External Review

Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the a)service is not medically **necessary** or is an experimental or investigational treatment 1 or (b) if applicable, such service is out-of network and an alternate is available in-network, you may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination that a Service is not Medically Necessary

If Aetna has denied coverage on the basis that the service is not medically **necessary**, you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal **appeal** process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal **appeal.**

In addition, your attending **physician** must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending **physician,** has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending **physician** must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this plan or one for which there exists a clinical trial (as defined by law.)

In addition, your attending **physician** must have recommended at least one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – your attending **physician** should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

Your Right to Appeal a Determination that an Alternate Service is available In-Network (if applicable)

If Aetna has denied coverage on the basis that an alternate service is available in-network (other than a clinical trial, which is covered immediately above), you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

- The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and
- You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial, or you and Aetna must agree in writing to waive any internal
- The attending **physician** certifies that such out-of -network service is (i) materially different than the alternate in-network service; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased

For the purposes of this section, your attending **physician** must be a licensed, board certified or board eligible **physician** qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If, through the first level of Aetna's internal **appeal** process, you have received a final **adverse benefit determination** upholding a denial of coverage on the basis that the service is not medically **necessary** or is an experimental or investigational treatment, or (if applicable) an alternate service is available in-network, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal **appeal,** you have 45 days from the receipt of such waiver to file a written request for an external **appeal.** Aetna will provide an external appeal application with the final **adverse benefit determination** issued through the first level of Aetna's internal **appeal** process or its written waiver of an internal **appeal.**

You may also request an external **appeal** application from the New York State Department of Insurance at 1-800-400-8882. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If you satisfy the criteria for an external **appeal**, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited **appeal** (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of the completed application. The External Appeal Agent may request additional information from you, your **physician** or Aetna. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending **physician** certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external **appeal**. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not medically **necessary** or approves coverage of an experimental or investigational treatment or determines that the out-of-network service (if applicable) should be covered under the Plan, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your responsibility to initiate the external **appeals** process. You may initiate the external **appeal** process by filing a completed External Appeal application with the New York State Department of Insurance. You or your designee may file an external **appeal** application; but if it's filed by your designee, you must consent to it in writing. The Department of Insurance may request from you written confirmation of the appointment of a designee. In addition, your attending **physician** has the right to pursue an external **appeal** of a retrospective **adverse claim determination**. To do so, the attending **physician** must complete an External Appeal application for health care providers. You must sign an acknowledgment of the request and a consent to release of any medical records.

Under New York State law, the completed request for **appeal** must be filed within 45 days of either: the date upon which you receive written notification from Aetna that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal **appeal**. Aetna has no authority to grant an extension of this deadline.

Covered Services and Exclusions

In general, this plan does not cover experimental or investigational treatments. However, this plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.

APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR PERSONS DIAGNOSED WITH ADVANCED CANCER

The following applies if a person: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the person's participating provider); and (ii) the participating provider, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the person's care would be appropriately provided by such facility.

In the event **Aetna** disagrees with the admission of or provision or continuation of care of the person by the facility, **Aetna** must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and **Aetna** will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

Aetna will keep records of your complaint for 7 years.

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(Appeals01)*

Policyholder:	475051
Group Policy No.:	GP-475051
Rider:	Texas Complaint and Appeals Health Rider
Issue Date:	July 1, 2010
Effective Date:	March 1, 2009

Complaint and Appeals - Health Coverage

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

Complaint and Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, or supply or benefit.

Such **adverse benefit determination** may be based on, among other things:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary.**

Appeal: A written request to Aetna to reconsider an **adverse benefit determination.**

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you, or the person you authorize to do so must call or write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Adverse Benefit Determinations

Urgent Care Claims

In the case of an **adverse benefit determination** for post-stabilization care following emergency treatment, Aetna will notify the treating **physician** or other health care provider within one hour of notification of the request.

For other urgent care claims, Aetna will make notification by telephone or electronic transmission of an **adverse benefit determination** as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make written notification of an **adverse benefit determination** within the time appropriate to the circumstance relating to delivery of the services but not more than three working days after the claim is made.

Concurrent Care Claim Extensions, Reductions or Terminations

If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, Aetna will make notification by telephone or electronic transmission of an **adverse benefit determination** of a concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

Post-Service Claims

Aetna will make notification of an **adverse benefit determination** as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination.** You also have an option to request an external review of the **adverse benefit determination.** If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to Aetna.

Your **appeal** may be submitted in writing and should include:

- Your name;
- The fund's name;
- A copy of Aetna's notice of an **adverse benefit determination;**
- Your reasons for making the **appeal;** and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID Card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

Aetna will acknowledge receipt, in writing, of your appeal within 5 working days of receiving it.

Group Health Claims

The review of an **appeal** of an **adverse benefit determination** shall be provided by Aetna physician not involved in making the **adverse benefit determination.**

Standard Appeals
(Applies for both Pre-Service and Post-Service Claims)

Pre-Service claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal.**

If an **adverse benefit determination** concerning specialty care is upheld upon Appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. **The adverse benefit determination** will be reviewed by a provider in the same or similar specialty as that which is the subject of the **adverse benefit determination** and the review will be complete within 15 days of its receipt of the request.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal.**

Expedited Appeals
(Applies for Urgent Care Claims May Include **appeals** regarding **concurrent care claim reductions or terminations of hospital stays**)

Aetna shall issue a decision on the **appeal** of an **adverse benefit determination** for an **Urgent Care Claim** within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the **appeal** has been received by Aetna. If Aetna has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is a life-threatening **Urgent Care Claim,** you may immediately appeal Aetna's **adverse benefit determination** to an independent review organization. You are not required to first comply with Aetna's appeals process. Please see the section entitled "External Independent Review", below.

External Independent Review

If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician**, selected by an independent External Review Organization, who has expertise in the problem or question involved. You may request a review by an independent external review organization assigned to the appeal by the Texas Department of Insurance for any appeal related to a pre-service **adverse benefit determination** involving a determination that the service, supply, or non-formulary drug is not **medically necessary.**

If your **adverse benefit determination** is for an **Urgent Care Claim** involving a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust Aetna's internal **appeals** processes.

For other than life threatening situations, to request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not **necessary** or was **experimental** or **investigational**; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal **appeal** processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the Independent Review Organization that will conduct the review of your claim. The Independent Review Organization will select a **physician reviewer** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the Independent Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the requested service or supply would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna will abide by the decision of the independent reviewer, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the Independent Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the Independent Review Organization and for the cost of the external review.

For more information about Aetna's External Review program, call the toll-free Customer Services telephone number shown on your ID card.

Exhaustion of Process

Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

You may not:

- contact the Texas Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- file a complaint or **appeal** with the Texas Department of Insurance; or
- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

1) before the 61st day after the date written proof of loss is filed as required under the policy; or
2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)